Alcoholism

Medical Team Approach to Treatment

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• **Various approaches to the treatment of alcoholism have been evaluated by the Los Angeles Rehabilitation Clinic since it began operating more than four years ago. A team approach similar to that used in the outpatient treatment of other chronic disabling diseases has been formulated. With the permission of the California State Department of Public Health (Division of Alcoholic Rehabilitation) preliminary figures of the follow-up study conducted by this department are presented and would tend to support the conclusion that alcoholism can be successfully treated on an outpatient basis.**

THIS PAPER is based upon four years of clinical experience as senior physician at the Los Angeles Alcoholic Rehabilitation Clinic operating in the Los Angeles City Health Department. This clinic is one of six established by the State Department of Public Health and operated by local governments under reimbursement contracts. The personnel of the clinic consists of the following:

A full-time clinic director, who is an internist, five part-time internists, a part-time psychiatrist, a part-time clinical psychologist, a public health nurse and a registered nurse, three full-time medical social workers, a full-time public health educator and three clerical workers.

The philosophy of the clinic is based upon the premise that alcoholism is a chronic disabling disease, of unknown cause, characterized by physiological, and/or psychological, and/or socioeconomical disturbances in an individual that impair his ability to function in a normal acceptable manner in his environment. As with other diseases of unknown cause, the aim of therapy at present is to maintain the individual as close to a normal physiological and functioning state as possible. The clinic staff also accepts that a patient under treatment may relapse and that this in itself is not a reason to discontinue treatment or to chastise the patient for poor motivation or for poor cooperation. As with patients who have such diseases as diabetes, arthritis and colitis, the aim of therapy is to decrease the periods of exacerbation of illness both in frequency and in duration and to increase the periods of normal functioning as much as possible.

At present the clinic offers treatment on an outpatient basis only to residents of Los Angeles County five days a week by appointment. Upon application to the clinic, the patient is given an appointment on one of the admitting days. At that time he is seen by:

1. The public health nurse, who evaluates his nutritional status and his environment.

2. A physician, who determines first whether or not emergency treatment is needed, and then on the basis of a short history form arrives at an impression as to whether or not the patient has a drinking problem and whether or not any physiological disturbances are apparent.

3. A social worker, who does a brief screening interview to determine the patient's status with regard to his socioeconomic functioning.

The patient then is seen by the clinic director, who reviews the recommendations of the physician, the social worker and the public health nurse and arrives at a decision as to whether or not to accept the patient for therapy. If the patient is accepted, arrangements are made for subsequent appointments.

For purposes of standardization, three states of alcoholism are accepted:

1. *Acute alcoholism* (under the influence of excessive alcoholic intake).

2. *Chronic alcoholism, active* (patient has been drinking in a pattern essentially unchanged in the period immediately before the time of making the diagnosis).

3. *Chronic alcoholism, in remission* (patient has had an established pattern of drinking which at the present time appears to have been interrupted, with the patient abstinent for longer time than any known previous period of abstinence).

For purposes of record keeping and evaluation of therapy, an alcoholic is defined as a person who because of the ingestion of alcohol has difficulty in functioning in a normal and acceptable manner in his society. There are several classifications:

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1. *The classic alcoholic.* This refers to a person who from the very first drink or exposure to alcoholic beverages responds in an abnormal manner both as to his tolerance and his ability to control his drinking. These persons are truly said to suffer from an "addiction of the body" and a "compulsion of the mind." They make up less than 10 per cent of all alcoholics.

2. *The reactive alcoholic.* This refers to persons who turn to the use of alcohol for its sedative or tranquilizing effect as a means of escape from a problem or situation whether imagined or real, and who, having turned to alcohol, may lose control of their drinking and become unable to maintain sobriety or complete abstinence. Some 70 to 75 per cent of alcoholics are of this order.

3. *The symptomatic alcoholic.* This is a person whose drinking is a sign or symptom of an underlying mental or physical defect or illness. Thus primarily the problem here is not alcohol, for the excessive ingestion of it is no different than the excesses indulged in in other fields by persons with underlying or primary mental or physical defects. Symptomatic alcoholics constitute approximately 10 per cent of all alcoholics.

4. *The purposeful alcoholic.* This term refers to the person who drinks at a specific time for an obvious purpose or effect and, upon obtaining it, then may totally abstain without difficulty. Approximately 5 or 10 per cent of alcoholics fit this description.

After summarization of the impressions of the various members of the staff at the time of admission, the patient is then assigned to one of the major subgroupings in the clinic for treatment. These may be listed as follows:

Medical supportive. The program here is similar to any medical clinic program for a chronic debilitating disease, employing medication and clinic visits with an internist and utilizing modified medical group therapy, and consultations with the psychiatrists, the social workers and the nurses as needed.

A brief description of the drugs used in the treatment program is as follows:

Disulfiram (*Antabuse®*), 0.5 gm. tablets, scored. Antabuse is used in a daily dosage of one-half to one tablet, usually taken immediately upon arising. It should never be given to a patient without fully informing him of the possible reaction to alcohol and that he should wait 48 to 72 hours after his last dose before attempting to take a drink. The reaction to alcohol may be aborted or prevented by the use of antihistamines either orally or intravenously. *Diphenhydramine* (*Benadryl®*) is our choice in doses of 30 to 50 mg., intravenously, for the acute reaction. We have found no contraindications to the use of Antabuse under proper supervision; and the only side reactions encountered were a very slight skin reaction which necessitated discontinuance of the drug, and an occasional mild gastric irritation which was relieved by taking the Antabuse after a meal or with an antacid preparation.

Antidepressants

Phenylethylhydrazine (*Nardil®*), 15 mg. tablets, used in doses of one tablet three times a day after meals, reduced to one tablet twice a day after desired effects obtained. Side effects are minimal and the most common is epigastric bloating and gas which is avoided by taking the tablets after meals.

Methyphenidate (*Ritalin®*), 5 mg., 10 mg., and 20 mg. tablets. Ritalin is used as an antidepressant and also as a stimulant. It is available in intravenous form, 10 mg. per cc. when reconstituted. It should not be used in persons prone to convulsions.

Dextroamphetamine sulfate (*Dexedrine®*), 5 mg. tablets, used most commonly in combination with *amobarbital* (*Dexamyl® formula*).

Tranquilizers

Meprobamate (*Equanil® or Miltown®*), in 200 and 400 mg. tablets. Adequate dosage is 200 or 400 mg. every 4 to 6 hours as needed.

Promazine (*Sparine®*), in 25 and 50 mg. tablets; also for parenteral use in 2 cc. and 10 cc. ampules, 50 mg. per cc. Primarily used intramuscularly in dosages of 50 to 100 mg. to quiet the agitated alcoholic and repeat 50 mg. every hour until desired effects obtained. Orally in dosages of 25 to 50 mg. every 4 to 6 hours as indicated.

Prozine® (each capsule containing a combination of meprobamate, 200 mg., and Sparine® 25 mg.). This is by far the most satisfying drug used. In the acutely intoxicated patient, two capsules every 4 hours until the patient has calmed down, then one capsule four times a day is usually sufficient. Using the combination, we have had no episodes of convulsions during the withdrawal period from alcohol such as have been reported when Sparine or meprobamate were used separately.

Barbiturates. The use of the barbiturates is to be avoided in the acutely intoxicated patient or the alcoholic, inasmuch as alcoholics usually react adversely to these drugs.

Antihistamines

Promethazine (*Phenergan®*), 25 mg. and 50 mg. tablets. Used for sleep but unfortunately some patients complain of drowsiness and heavy headedness in the morning.

Diphenhydramine (*Benadryl®*), 25 mg. and 50 mg. capsules. Fifty to 100 mg. for sleep at night is

tolerated quite well. The drug is used intravenously or intramuscularly during withdrawal from alcohol as adjunct to other medications.

Vitamins and Nutritional Supplements

Vitamins are given routinely, using a multiformula vitamin and mineral from therapeutic formulas and maintenance formulas. The parenteral use of vitamins is usually restricted to the acute phase of detoxification in a patient who appears to suffer from malnutrition or complains of combined system involvement. B_1 and B_6 and B_{12} are the three "neurotropic" vitamins and as such have the biggest role to play in the treatment of alcoholics. The use of B_1 has been over-magnified and it is specific only in cases in which a B_1 deficiency exists due to poor eating habits or excessive alcohol intake. In the presence of a combined system disease, administration of B_1, B_6 and B_{12} parenterally is mandatory, as with any other combined system neuritis. A routine form of use of B_1, B_6 and B_{12} would be a B_1 and B_6 mixture of 50 mg. per cc. plus the addition of vitamin B_{12}.

Psychiatric supportive. Here the patient is dealt with primarily by the clinic psychiatrist. This involves either individual therapy or group therapy. Group therapy here is usually more intensive than the medical group therapy referred to previously. Here again frequent consultations are available between the internist, the psychologist, social worker and the public health nurse.

Social supportive. Here the patients, who are predominantly in need of social guidance and help in adjusting to family relations, employment problems, etc., are under the major supervision of the social workers, who utilize the consultation privileges of the internists, psychiatrist, public health nurse and others.

As the patient progresses through his treatment program, staff conferences which are held weekly will periodically review his progress or failure, and modifications in the treatment program are made as needed. Improvement is measured as follows:

1. Improvement in the economic status and productivity of the patient.

2. Improvement in his family and interpersonal relationship.

3. Improvement in his physical and emotional state.

4. Improvement as measured by interruptions or modifications of his previous drinking pattern resulting in shorter periods of drinking and longer periods of total abstinence.

Recently the clinic psychologist has attempted to initiate a program by which each new patient may be profiled on a system of cards which may be fed into a mechanical type computer system. These cards are an attempt to measure an individual's standing and previous history with relations to his functioning in the various fields that previously were enumerated. At follow-up intervals of approximately three months, six months, nine months and a year, each patient will again be reevaluated, his profile remeasured, and progress thus may be delineated on a scale that is readily accessible to machine type computations and assembling. In April of 1961, preliminary figures of a follow-up study of the patients in the six state alcoholic rehabilitation clinics was made by the California State Department of Public Health. This was concerned with a sample of 552 male and female patients who were admitted or readmitted to the various clinics during the period of February to June, 1959. Interviewing of a selected group of these patients was accomplished primarily in May and June of 1960 and a summary of the findings is as follows:

1. Eighty-three per cent of the respondents said that clinic treatment had been beneficial. Seventeen per cent said they had received no benefits.

2. Seventy-six per cent of the respondents showed overall improvements between the time they were taken by the clinic and the time of interview, as measured by scores achieved in the six problem areas combined with changes in the drinking pattern. Eleven per cent showed no improvement and 13 per cent were considered worse at the time of interview than at the time of admittance.

3. Sixty-six per cent of the respondents with a known drinking pattern at the time they entered, showed improvement at the time of interview. Twenty-six per cent were the same, 8 per cent were worse.

4. Seventy-five per cent of the respondents were at a higher employment or income level at the time of interview than at the time treatment began.

5. Sixty-one per cent of the respondents had improved marital status or relationships at time of interview as compared with the time of admittance.

6. Fifty-eight per cent of the respondents with recent arrests records had fewer arrests in the six months before interview than in the six months before admittance.

7. Fifty-five per cent of the respondents with a health problem at the time of intake had improved health at the time of interview. Fifty-one per cent of the respondents who had recent hospital histories had fewer hospitalizations in the six months before interview than in the six months before admittance.

8. Forty-four per cent of the respondents with problems related to child care and custody at the

time of admittance, showed improvement in this area at the time of interview.

Although these results are not conclusive, they are based upon actual case histories and follow-up studies which attempt to set forth in the treatment of alcoholic patients specific criteria of improvement which may be evaluated so that subsequent measurements can be made at future follow-up studies.

In conclusion it may be stated that the six pilot clinic programs of the State Department of Public Health, and specifically the Alcoholic Rehabilitation Clinic of Los Angeles, have demonstrated over the past four-year period that alcoholism ought to be approached with therapists expecting no more of an alcoholic than they would of a person with diabetes or arthritis or epilepsy. If we permit the alcoholic to have some dignity in his attitude toward his illness, as we do with persons who have the other diseases mentioned, then we can expect to achieve as much success in treatment. In the past, society has driven alcoholics from the church, from the physician's office and from the family. It has called him morally weak, sinful, and undependable, and it refused him the opportunity of being treated with dignity, of being accepted as a medically ill individual suffering from a complex, chronic, perplexing disease. We forced him in his own defense to try to find his comfort and his recovery in institutions and facilities outside of those existing today for all other individuals afflicted with a chronic disabling illness. It was not the alcoholic who lacked motivation, a term which so conveniently excused the shortcomings of our therapy, but rather society, the medical profession and also our organized religions who lacked the motivation to seek the cause, the treatment, the prevention and eventual eradication of this problem, alcoholism.

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